CHAPTER He-W 500 MEDICAL ASSISTANCE

PART He-W 530 SERVICE LIMITS, CO-PAYMENTS, AND NON-COVERED SERVICES

Readopt with amendment He-W 530.02, effective 6/30/2007 (Document #8929), as amended effective 11/1/11 (Document #10016), and as amended effective 11/18/14 (Document #10716), to read as follows:

He-W 530.02 Recipients Subject to Service Limits, Co-Payments, and Non-Covered Services.

(a) All recipients shall be subject to service limits in accordance with He-W 530.03.

(b) All recipients shall be subject to the co-payments specified in He-W 530.04, except for:

(1) Recipients with income below 100% of the federal poverty level (FPL);

(2) Recipients residing in a nursing facility, hospital intermediate care facility for individuals with intellectual disabilities, or other medical institution;

(3) Recipients participating in the home and community based care (HCBC) waiver programs;

(4) Recipients receiving services that relate to pregnancy, in accordance with 42 CFR 447.53(b)(2), or any other medical condition that might complicate the pregnancy; and

(5) Recipients under the age of 18.

(c) All recipients shall be subject to non-covered services provisions in accordance with He-W 530.05.

Readopt with amendment He-W 530.03, effective 6/30/2007 (Document #8929), as amended effective 9/21/07 (Document # 8983), as amended effective 3/12/08 (Document #9103), as amended effective 1/17/09 (Document #9366) as amended effective 1/1/10 (Document #9622), as amended effective 6/25/10 (Document #9736), as amended effective 11/1/11 (Document #10017) as amended effective 3/1/2012 (Document #10090), as amended effective 9/28/13 (Document #10427), and as amended effective 8/15/14 (Document #10657), to read as follows:

He-W 530.03 Service Limits. The following service limits shall apply to each recipient who is subject to service limits, per state fiscal year, with exceptions noted:

(a) The hearing aid evaluation or a hearing aid consultation shall be limited to one service every 2 years since the last date of service;

(b) Hospital services shall be limited as follows:

(1) Outpatient hospital services shall be limited to 12 visits per state fiscal year;

(2) Services provided in an emergency department (ED) or an urgent care setting shall not be considered outpatient hospital services, and shall not apply toward the limit established in (1) above;

(3) Physician services shall be unlimited except when associated with an outpatient hospital visit, in which case they shall be limited to 12 visits per state fiscal year; and

(4) Services that are described individually in component parts of this chapter, such as therapy services or radiology services, and that are associated with an outpatient hospital, ED or urgent care visit shall be subject to the service limits which apply to that individual service;

(c) Physician and advanced practice registered nurse (APRN) services performed in the inpatient hospital setting shall be limited to one visit per quality improvement organization (QIO) approved day of stay;

(d) Podiatry services shall be limited to 4 visits;

(e) Therapy services, including physical, occupational and speech therapy, shall be limited to 80, 15-minute units per recipient. The 80 units may be used for one type of therapy or for any combination of therapies;

(f) Vision care services shall be limited as follows:

(1) One refraction to determine the need for glasses, no more frequently than every 12 months;

(2) Replacement of lenses or at the discretion of the recipient, lenses and frames, when the refractive error changes .50 diopter or more in both eyes;

(3) Replacement of nickel frames after 12 months, if the recipient has a documented allergy to nickel demonstrated by skin irritation and wearing down of the frame in the affected area; and

(4) One repair of glasses every 12 months, including replacement of the broken part(s) only;

(g) Wheelchair van services shall be limited to 24 trips, either one-way or round trip;

(h) X-ray services shall be limited as follows:

(1) X-ray services for diagnostic purposes shall be limited to 15 x-rays; and

(2) X-ray services provided for radiation therapy shall not be limited; and

(i) If a recipient is covered by medicare and medicare pays at least half the medicaid program rate for a covered service which is subject to limits, that service shall not be counted against such limits.

Readopt with amendment He-W 530.06, effective 6/30/2007 (Document #8929), to read as follows:

He-W 530.06 Recipient Responsibility for Payment.

(a) The recipient shall be responsible for payment of the entire cost of a service if:

(1) The individual is not eligible for medicaid on the date of service;

(2) The service is not covered by medicaid;

(3) The provider is not a NH enrolled medicaid provider; or

(4) The provider is no longer taking additional medicaid recipients, but the recipient chooses to receive the service anyway as a private patient.

(b) The recipient shall be informed of these provisions verbally at the initial determination of eligibility and at each redetermination of eligibility by the department.

APPENDIX B

RULE	STATE OR FEDERAL STATUTE THE RULE IMPLEMENTS
He-W 530.02	42 USC 1396o; 42 CFR 447.53
He-W 530.03	RSA 167:3-h, IV; 42 CFR 440.230(d); 42 CFR 447.53-55; RSA 326-B:2, I; RSA 326-B:11
He-W 530.06	42 CFR 447.15